The Antitrust Bulletin

The Journal of American and Foreign Antitrust and Trade Regulation

Hospital responses to physician competition

BY DAN MULHOLLAND*

Hospital responses to physician competition

BY DAN MULHOLLAND*

I. INTRODUCTION

Full service hospitals today are faced with competition from all sorts of entities. The most potent form of competition often comes from entities that are either wholly or partly owned by physicians who also have privileges on the hospital's medical staff. A recent report by the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on competition in health care suggested that this phenomenon had both pro- and anticompetitive aspects.[1] However, competition from physician-owned entities often puts the hospital at a substantial competitive disadvantage, since physicians who have financial relationships with competitors not only have an incentive to divert business away from the hospital, but also continue to refer patients with less-than-desirable reimbursement to the hospital. Financial relationships with competitors can also interfere with and sometimes compromise a physician's ability to carry out his or her medical staff responsibilities, such as emergency call or service on peer review committees.

* Senior Partner, Horty, Springer & Mattern, P.C., Pittsburgh, PA.

AUTHOR'S NOTE: *I wish to acknowledge all the attorneys of Horty Springer who contributed to this article.*

[1] FEDERAL TRADE COMMISSION, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 17 (2004), http://ftc.gov/reports/healthcare/040723 healthcarerpt.pdf [hereinafter FTC/DOJ REPORT].

© *2007 by Federal Legal Publications, Inc.*

A review of the law on point makes it clear that hospitals may adopt policies that make physicians who have financial relationships with competing entities ineligible for medical staff appointment, clinical privileges, or other prerogatives associated with medical staff appointment (e.g., eligibility for leadership positions or financial assistance from the hospital). Such responses can constitute a legitimate way for hospitals to carry out their legal duty to serve their patients and the community as a whole.

I. COMPETITIVE RELATIONSHIPS BETWEEN PHYSICIANS AND HOSPITALS

Traditionally, physicians and hospitals have peacefully coexisted with one another and have enjoyed a mutually beneficial relationship. Physicians derived most of their income from providing professional services, while hospitals relied on "technical revenue" to be reimbursed for the space, equipment, supplies, and personnel used by the physicians to treat their patients in the facility.[2] In the traditional setting, most physicians are not employed by a hospital, but instead are appointed to the hospital's medical staff and granted clinical privileges to treat patients at the hospital. Unless the physician performs some other unique service for the hospital, no money changes hands and both the doctor and the hospital look to their own separate revenue streams for reimbursement.

In recent years, however, a variety of factors and trends have blurred this traditional relationship. In some situations, in order to assure adequate access to medical services in the community, hospitals have provided income guarantees to physicians recruited to their service area. In other instances, hospitals or related organizations have employed physicians to provide medical services to patients. But doctors too have begun to offer services that were historically only offered by hospitals. As a result of payment policies and technological advances, there has been a significant increase in investment by physicians in health care facilities, including imaging facilities, ambulatory surgery centers, and even hospitals. This allows the physician-investor to supplement his or her professional income with revenue from the facility services that he or

---

2 FTC/DOJ REPORT, *supra* note 1, at 12.

she orders. Many of these opportunities are quite lucrative for physician-investors and their joint venture partners.

Various studies have suggested that ownership interests in facilities can distort physician decisionmaking and result in overutilization.[3] The Office of Inspector General of the Department of Health and Human Services (OIG) has also raised questions about the quality of the oversight of ambulatory surgery centers by state licensure and accreditation agencies.[4] When physicians invest in limited service hospitals, surgicenters or diagnostic facilities, they more often than not duplicate facilities and services already available at the hospital, thus increasing costs for Medicare and other payors.

There is also little doubt that when physicians have an ownership or investment interest in a facility, they will refer patients to that facility whenever they can. This is not only intuitive but has been demonstrated empirically as well.[5] Moreover, facilities that employ physicians can require their employed physicians to refer to them without violating the Medicare antikickback statute (which does not apply to employment relationships)[6] or (with few exceptions) the so-called Stark Law.[7]

---

[3] Jean M. Mitchell & Jonathan H. Sunshine, *Consequences of Physicians' Ownership in Health Care Facilities—Joint Ventures in Radiation Therapy*, 327 NEW ENG. J. MED. 1497 (1992); Brian E. Kouri, R. Gregory Parsons & Hillel R. Alpert, *Physician Self-Referral for Diagnostic Imaging*, 179 AM. J. RADIOLOGY 843 (2002); Jean M. Mitchell, *Effects of Physician-Owned Limited Service Hospital* (2005), http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.481v1.

[4] DEPARTMENT OF HEALTH AND HUMAN SERVICES, QUALITY OVERSIGHT OF AMBULATORY SURGERY CENTERS—A SYSTEM IN NEGLECT, February 2002, http://oig.hhs.gov/oei/reports/oei-01-00-00450.pdf.

[5] William J. Lynk & Carina S. Longley, *The Effect of Physician-Owned Surgicenters on Hospital Outpatient Surgery*, 21 HEALTH AFFAIRS 215 (2002).

[6] 42 U.S.C.A. § 1320a-7b(b) (2006).

[7] 42 C.F.R. § 411.354(d)(4) (2007). The Stark Law generally prohibts physicians from referring Medicaid and Medicare patients for certain "designated health services" (including hospital services) to entities with whom the physician or physician's family members have a financial relationship unless the relationship falls within an exception enumerated in the statute or regulations. One of the key exceptions covers employment relationships.

Therefore, requiring a physician to choose between a financial relationship with a competitor or eligibility for medical staff appointment simply levels the competitive playing field.

In its final regulation implementing the Stark Law, the Centers for Medicare & Medicaid Services (CMS) specifically acknowledged that physician-owned hospitals could possess a competitive advantage over those with no physician ownership.[8] CMS also recognized in those regulations that notwithstanding the whole hospital exception in the statute, physician ownership of hospitals, particularly specialty hospitals, could implicate the Medicare antikickback statute.

Physician ownership in facilities can also lead to unfair competition with the hospital, based on the ability of the physician-investors to steer high-paying patients to their facility while directing indigent patients and Medicaid beneficiaries to the hospital. Similarly, a study by the United States General Accounting Office (GAO) concluded that specialty hospitals, which are typically owned in whole or in part by physicians, tend to treat patients who are less sick than patients with the same diagnosis at general hospitals.[9]

Competition is further skewed by the fact that physician-owners of outpatient facilities may be less willing to shoulder their fair share of hospital medical staff duties, such as emergency room call coverage and service on peer review committees. This is not surprising since their economic interests lie elsewhere. But the effect of this trend is that hospitals are increasingly forced to compensate physicians for services that previously were obligations of staff appointment. This imposes additional costs on hospitals, making it even more difficult to compete with the entities owned by the very physicians demanding payment.

The hospital peer review process itself can even be corrupted when physicians with outside financial interests fail to recuse themselves when called upon to review the clinical work of their

---

[8] 69 Fed. Reg. 16084 (2004).

[9] U. S. GENERAL ACCOUNTING OFFICE, SPECIALTY HOSPITALS: INFORMATION ON NATIONAL MARKET SHARE, PHYSICIAN OWNERSHIP, AND PATIENTS SERVED, GAO-03-683R (2003), http://www.gao.gov/new.items/d03683r.pdf.

fellow investors, as the criminal plea bargain agreement in the case of *United States v. United Memorial Hospital.*[10] illustrates. Finally, while there may be differences of opinion about the quality of care rendered in investor-owned versus nonprofit hospitals, most physician-owned facilities (especially outpatient facilities and physicians' offices) lack the kind of rigorous peer review and quality improvement process that is second nature to full-service hospitals.

Nonprofit community hospitals are especially vulnerable to competition from physician-owned facilities and services. Physician-investors in competing entities have a financial incentive to divert services that still generate a financial margin for the hospital to the entities that they own. This makes it difficult for the hospital to subsidize essential community services that traditionally lose money, such as the emergency room, obstetrics, psychiatric programs, and disaster preparedness. To the extent that competition from such "carve-out" entities jeopardizes the hospital's ability to fulfill its community service mission, the hospital clearly has the authority to protect its interests. In fact, the board of the hospital could very well be in breach of its fiduciary duty if it did nothing to respond to such a threat. Considering a policy that would deny medical staff appointment and clinical privileges to competing physicians is a legitimate exercise of the board's discretion.

It is also important to consider the ethical implications of physician ownership of health care facilities in this context. The American Medical Association (AMA) has taken the position that physician investment in health care facilities should generally take place only if "there is a definite need in the community for the facility and alternative financing is not available."[11] But where a physician-owned entity directly competes with an existing hospital, it is hard to see how the physician-owned entity would be truly needed, as opposed to merely duplicating the services offered by the hospital.

---

[10] No. 1-01-CR-238 (W.D. Mich. Jan. 8, 2003).

[11] American Medical Association, *Opinion of the American Medical Association Council on Ethical and Judicial Affairs*, Opinion E-8.032 (1994), http://www.ama-assn.org/ama/pub/category/8472.html.

The AMA has also stated that physicians have an ethical obligation to share in providing care to the indigent.[12] To the extent that physicians invest in a facility that drains profitable services from their local hospital, physician-owned entities can hardly be said to be consistent with this duty. Thus, the effect of carve-out competition on the ability of physicians to practice in an ethical manner provides an additional basis for a hospital board policy regarding physician competition.

II. MEDICAL STAFF STATUS OF PHYSICIAN COMPETITORS

Since physician ownership of competing entities places hospitals at a competitive disadvantage, hospitals should be able to determine that physicians with a financial relationship with a competing facility are ineligible for medical staff appointment and associated prerogatives (such as holding medical staff leadership positions). Such an action would be a legal and procompetitive strategic decision of the hospital.

For the purpose of this discussion, the term "financial relationship" means an ownership or investment interest or compensation arrangement.[13] Such a financial relationship would not include a situation where a physician merely had privileges to treat patients at or otherwise refer patients to another facility. Thus, such a policy would not affect the physician's ability to practice elsewhere or prevent the physician from referring patients to the hospital's competitors. It would simply preclude the physician from being appointed to the medical staff if he or she had the kind of financial relationship with a competitor that both public policy and common sense have determined would induce the physician to refer patients to another entity instead of the hospital.

---

[12] American Medical Association, *Opinion of the American Medical Association Council on Ethical and Judicial Affairs,* Opinion E-9.065 (1994), http://www .ama-assn.org/ama/pub/category/8538.html.

[13] This is the same definition used for this term in the Stark Law. 42 U.S.C. § 1395nn(a)(2) (2003).

A. *The nature of hospital medical staff appointment*

The medical staff is legally a constituent part of the hospital, having been created by and remaining ultimately accountable to the hospital governing board.[14] The medical staff has the responsibility of performing essential functions on behalf of the hospital in accordance with licensure laws and accreditation requirements.[15] The Medicare Conditions of Participation for Hospitals (COPs), which set forth minimum requirements for hospitals participating in the Medicare program, require that the medical staff be accountable to the governing body for the safety and quality of the medical care provided to patients.[16]

While the medical staff is accountable to the board for safety and quality, the COPs (as well as state licensure laws and regulations) place the legal responsibility of operating the hospital and of appointing physicians to the medical staff on the board precisely for safety reasons. Specifically, the standard relating to the medical staff states:

> Standard: Medical staff. The governing body must: (1) *Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;* (2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff; (3) Assure that the medical staff has bylaws; (4) Approve medical staff bylaws and other medical staff rules and regulations; (5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients; (6) Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and (7) Ensure that under no circumstances is the accordance of staff

---

[14] Exeter Hosp. Med. Staff v. Bd. of Trustees of Exeter Hosp., 810 A.2d 53 (N.H. 2002); *cf.* American Medical Association, Opinion of the American Medical Association Council on Ethical and Judicial Affairs, E-4.05, http://www.ama-assn.org/ama/pub/category/8343.html. *See also* Johnson v. Misericordia Cmty. Hosp., 294 N.W.2d 501 (Wis. App. 1980), *aff'd*, 301 N.W.2d 156 (Wis. 1981); and Ramey v. Hosp. Auth. of Habersham County, 462 S.E.2d 787 (Ga. App. 1995).

[15] American Medical Association, Opinion of the American Medical Association Council on Ethical and Judicial Affairs, E-4.04, http://www.ama-assn.org/ama /pub/category/8342.html.

[16] 42 C.F.R. § 482.22(b) (2007).

> membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society. [17]

Subsection 1 thus requires that hospitals participating in the Medicare program have discretion to determine that physicians who have financial relationships with competing facilities or services are not "eligible candidates for appointment to the medical staff."

There is no constitutional right to be appointed to a medical staff, even in a public hospital.[18] In cases in which physicians have challenged hospital actions denying or revoking their medical staff appointment and clinical privileges, courts have accorded great deference to the hospital board. This principle has been so long and well established that it needs almost no support, but the oft-cited case of *Sosa v. Board of Managers of the Val Verde Memorial Hospital*[19] sums it up:

> No court should substitute its evaluation of such matters for that of the Hospital Board. It is the Board, not the court, which is charged with the responsibility for providing a competent staff of doctors. . . . Human lives are at stake, and the governing Board must be given discretion in its selection so that it can have confidence in the competence and *moral commitment* of its staff.[20]

In *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*,[21] Judge Posner concluded that this discretion would extend to decisions that would render ineligible for appointment physicians with affiliations that conflict with the hospital's strategic objectives. The plaintiff in that case, CompCare HMO, argued that hospitals whose medical staffs were "controlled" by physicians affiliated with the competing Marshfield Clinic improperly "restricted staff privileges at those hospitals of independent physicians." The court concluded:

> Hospitals are not public utilities, required to grant staff privileges to anyone with a medical license. The Marshfield Clinic's reputation for

---

[17] 42 C.F.R. § 482.12(a) (2007) (emphasis added).

[18] Hayman v. City of Galveston, 273 U.S. 414 (1927).

[19] 437 F.2d 173 (5th Cir. 1971).

[20] *Id.* at 177 (emphasis added).

[21] 65 F.3d 1406 (7th Cir. 1995).

> high quality implies selectivity in the granting of staff privileges at hospitals affiliated with the Clinic. Physicians employed by the Clinic, which has its own HMO, are hardly to be expected to steer their patients to another HMO, as they would be doing if they used their control of hospital staffs to induce the hospital to join another HMO. And given the extensive network constituted by the physicians either employed by or contracting with the Clinic, they would have little occasion to "cross-cover" with other physicians and would be reluctant to do so if, as is completely consistent with CompCare's version of the "essential facilities" doctrine, the Clinic maintains a reputation for high quality by being selective about the physicians to whom it entrusts its customers.[22]

The courts have long permitted hospitals to withhold medical staff appointment and clinical privileges from otherwise qualified practitioners based on "economic" factors. In such cases, the courts have deferred to a decision of the hospital's governing board that services can be more efficiently provided in a particular manner, or that appointing every qualified practitioner would prevent the hospital from effectively carrying out its community service mission. Examples include credentialing decisions relating to exclusive contracts with a selected group of physicians, and medical staff development plans that determine the number and type of physicians that can best serve the needs of the hospital and the community.[23]

The Joint Commission, a private organization that accredits the majority of the hospitals in the country, specifically contemplates that accredited hospitals may establish criteria for medical staff appointment that go beyond those related to clinical competence, including the ability to provide adequate facilities and support services to the physician and his or her patients and patient care needs for additional staff members.[24] The existence of a competing interest or the extent to which the physician intends to use the hospital's facilities is just one component of such criteria.

---

[22] *Id.* at 1413–14.

[23] *See* Nathan Hershey, *A Different Perspective on Quality*, 17 AM. J. MED. QUALITY 242 (2002).

[24] THE JOINT COMMISSION, 2007 COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS, MS.5–5.13 (2007).

B. *Judicial decisions involving eligibility of physicians who compete with hospitals for medical staff appointment*

Courts have also deferred to hospital decisions that physicians who have financial relationships with facilities that compete with the hospital are ineligible for medical staff appointment and clinical privileges. In *Mahan v. Avera St. Luke's*,[25] a nonprofit hospital in Aberdeen, South Dakota, adopted a medical staff development plan that had the effect of preventing physicians affiliated with a competing surgicenter from applying for medical staff appointment. The Supreme Court of South Dakota upheld the hospital's policy and the board's authority to adopt it. In doing so, the court specifically noted that the policy, like most hospital policies that would have the effect of denying staff appointment to competitors, was based on the board's fiduciary obligation to do what is in the best interest of the community:

> When making these decisions, the Board specifically determined that the staff closures were in the Aberdeen community's best interests, and were necessary to insure 24-hour neurosurgical coverage for the Aberdeen area. By preserving the profitable neurosurgical services at [Avera St. Luke's], the Board also insured that other unprofitable services would continue to be offered in the Aberdeen area. [Avera St. Luke's] cannot continue to offer unprofitable, yet essential services including the maternity ward, emergency room, pediatrics and critical care units, without the offsetting financial benefit of more profitable areas such as neurosurgery. The Board responded to the effect that the [surgicenter] would have on the economic viability of [Avera St. Luke's] hospital and the health care needs of the entire Aberdeen community. These actions were within the power of the Board. It surely has the power to attempt to insure [Avera St. Luke's] economic survival. As such, the courts should not interfere in the internal politics and decision making of a private, nonprofit hospital corporation when those decisions are made pursuant to its Corporate Bylaws.[26]

A governing board's authority to ensure the continued viability of the hospital was also central to the court's decision in *Walborn v. UHHS/CSAHS-Cuyahoga, Inc.*[27] There, the hospital adopted a conflict of interest credentialing policy that prohibited physicians from

[25] 621 N.W.2d 150 (S.D. 2001).

[26] *Id.* at 156.

[27] No. CV-02-479572 (C.P. Cuyahoga County, Ohio, 2003), *appeal docketed*, July 16, 2003.

applying or reapplying for medical staff appointment if they had a financial relationship with a competing entity or held an administrative or leadership position with a competing entity. In finding that adoption of the credentialing policy was a legitimate exercise of the governing board's authority, the court first noted that "ensuring the continued viability of a hospital is a legitimate basis upon which to implement a policy or program." The court adopted as a finding of fact the testimony of the chief executive officer of the competing entity, who had stated:

> For a not-for-profit hospital to be able to provide care, it has to be viable. If it isn't viable, you cannot fulfill your mission, which is provide care in the community [sic] . . . . [A hospital] board has a fiduciary responsibility to ensure that the hospital is capable of carrying out its mission, and if the hospital is in bankruptcy, it can't do that, so they have a responsibility to see that the hospital exists.[28]

The court then concluded as a matter of law that hospitals "may make threshold requirements for staff privileges to exclude physicians whose business interests conflict with those of [the hospital]."[29] It is important to note that the court based this conclusion on the widely accepted legal principle that "[t]he board of a nonprofit hospital exerts ultimate authority over financial and staffing decisions of the hospital."[30] The court merely extended this principle to determine that governing boards, in establishing eligibility requirements for medical staff membership, may also consider factors that affect the continued viability of the hospital. Since federal and state law generally recognize a governing board's authority to establish eligibility requirements for medical staff membership, the *Walborn* court's reasoning may be useful when this issue is raised in other states.

Another case which supports the ability of hospitals to consider the effect of physician competition when making credentialing decisions is *Williamson v. Sacred Heart Hospital of Pensacola*.[31] In that case, a radiologist who was denied medical staff appointment at two

---

28 *Id.* at ¶ 8.

29 *Id.* at ¶ 14.

30 *Id.* at ¶ 20.

31 No. 89-30084-RV 1993 WL543002 (N.D. Fla. 1993).

Florida hospitals and membership in an independent practice association sued claiming that, among other things, the denials violated the antitrust laws because she was the owner of a competing free-standing diagnostic imaging center. Although the court found no evidence to support her claim that this was the reason for the hospitals' actions, the court concluded that denying appointment to a competitor would nonetheless be justified, since the plaintiff was a "very formidable competitor." According to the court:

> In light of plaintiff's position in the market, granting her any type of privileges while she still operated her own clinic would put Sacred Heart in the position of supporting its main competition. Essentially, Sacred Heart would be competing with itself. Faced with this possibility, it clearly had a rational, pro-competitive reason for acting independently to deny Dr. Williamson's request for privileges.[32]

Likewise, in *Rosenblum v. Tallahassee Memorial Regional Medical Center, Inc.*,[33] a Florida trial court upheld the decision of a hospital that a heart surgeon who had a contractual commitment to a competing hospital, which caused his interests and allegiance to lie elsewhere, was ineligible for staff appointment. The court stated its reasoning as follows:

> But in the area of fair and clean competition, Dr. Rosenblum has contractual responsibilities to [the competing hospital] that I think are valid considerations of [Tallahassee Memorial] as to whether they will grant medical privileges in the field of heart surgery to the program chairman and the developer of a competing hospital. And the competition between hospitals, not only in Tallahassee but apparently on a national scale, is intense. It is real. It is not imaginary.[34]

In *Berasi v. Ohio Health Corp.*,[35] a health system board of trustees drafted a resolution that terminated the privileges of any physician who had an investment interest in a for-profit hospital that was in competition with the health system's hospital. The policy allowed for "fair hearing" procedures for such terminations, but these were

---

[32] *Id.* at 34.

[33] No. 91-589 (Fla. 2d Cir. 1992).

[34] *Id.* at 4.

[35] No. 04CVA03-1406 (C.P. Franklin County, Ohio 2004).

limited to evidence showing the policy had been "incorrectly applied to the Practitioner based upon inaccurate facts." The system's hospital subsidiary subsequently revoked the privileges of 17 staff physicians who had invested in a new surgical hospital. The physicians sued, alleging violation of the bylaws that provided that clinical privileges could not be terminated except for reasons related to patient care and that the resolution passed by the board was not a valid modification of the bylaws. The court denied the physicians' motion for a temporary restraining order, and the physicians ultimately withdrew their action.

A similar result was reached in *Biddulph v. Eastern Idaho Regional Medical Center.*[36] The hospital board adopted a policy giving it the power to remove a physician from the hospital's medical staff if the physician held a financial interest in a competing facility or diverted patients to another facility for his own financial gain. Pursuant to this policy, the hospital revoked the privileges of five physicians who violated the hospital policy by referring patients to a physician-owned facility in which they were investors. The policy was not referenced in the bylaws, and the physicians argued that it operated as an unauthorized unilateral amendment. The physicians filed an eight-count complaint, but the hospital rendered the injunctive issue unripe by voluntarily deferring the effective date of the termination of the physicians' medical staff appointment. The court deferred on four of the eight counts, dismissed two of the counts, and denied the motion to dismiss as to the two remaining counts. It was subsequently reported that the parties issued a joint press release on June 30, 2005, indicating that the case had settled, without payment of financial consideration.

The one case that stands out as an exception to this trend is *Murphy v. Baptist Health.*[37] Six physicians who held an indirect interest in a heart hospital sought an injunction against the enforcement of a hospital's conflict of interest policy. The policy prohibited physicians with an ownership or investment interest in a competing hospital from being eligible for medical staff appointment or reappointment. A lower

---

[36] No. CV-04-1219 (7th Jud. Dist. Idaho 2004).

[37] 365 Ark. 115 (Ark. 2006).

court found that the physicians would likely succeed on the merits of their tortious interference claim and that the policy violated the Medicare antikickback statute. The lower court also found that the policy caused the physicians irreparable harm and disrupted the physicians' relationships with patients. While the Arkansas Supreme Court disagreed with the circuit court in finding that the hospital's policy would not violate the Medicare antikickback statute,[38] it did find that the hospital improperly interfered with the doctor-patient relationship by possibly depriving patients of their choice of physician. Therefore, the court affirmed the lower court's findings that the physicians would likely succeed on the merits of their claim of tortious interference and that the physicians would suffer irreparable harm.

On balance, the weight of the case law leads to the conclusion that it is legitimate for a hospital to adopt a policy declaring physicians who have a financial relationship with a competing facility or service to be ineligible for medical staff appointment and clinical privileges. Such a policy would not require the physician to admit any patients to the hospital or otherwise refer business there as a condition of medical staff appointment. It would simply mean that, if the physician is going to have access to the hospital's facilities, equipment and personnel, the physician must make a choice to forgo a financial relationship with the hospital's competitors that would induce the physician to direct business to the competitor's facility. Such policies are not designed to exclude physicians, but rather present the physician with a simple option—work with the hospital in support of its mission and commitment to the community or compete.

C. *Minimum volume requirements*

A hospital policy requiring a physician to perform a minimum percentage of his or her practice at the hospital would also be completely in line with the hospital's community service objectives. It would also not violate the Medicare antikickback statute, since the

[38] The OIG recently stated in its Supplemental Compliance Guidance for Hospitals that a hospital credentialing policy that categorically disqualifies physicians with significant conflicts of interest from medical staff appointment would not implicate the antikickback statute. 70 Fed. Reg. 4869 (2005).

hospital has not required the physician to refer any particular number of patients to the hospital. The physician would only be required to refrain from economically discriminating against certain classes of patients, or unfairly saddling the hospital with a disproportionate share of the responsibility to care for the community's indigent population.

Courts have upheld hospital policies requiring physicians to perform a certain minimum volume of procedures as a condition of medical staff appointment, holding that such requirements help maintain quality and promote patient safety. For example, in *Kerth v. Hamot Health Foundation*,[39] two cardiovascular surgeons filed an antitrust suit alleging a conspiracy (among a hospital, a group of cardiologists and a competing group of cardiovascular surgeons) to destroy their practice, after they lost their privileges because they failed to perform a sufficient number of procedures. The hospital had instituted a minimum volume requirement of 100, which neither surgeon could meet. Summary judgment was granted for the defendants. The volume requirement, said the court, was supported by studies linking volume and lower mortality rates. Only after the surgeons' volume dropped into the teens (during the short period in 1991–1992 during which the volume requirement was not in effect) did the hospital determine that their surgery volume had become so low that it was no longer possible to conduct a statistically meaningful evaluation of the quality of care they were providing. The court said that the hospital "was perfectly justified in requiring a minimum level of proficiency."

Likewise, in *United States ex rel. Perales v. St. Margaret's Hospital*,[40] a court granted summary judgment in favor of the defendant hospital in a *qui tam* suit filed under the False Claims Act.[41] The suit, which was filed by a disgruntled physician, claimed that a number of practice acquisitions and recruitment agreements between the hospital and other physicians violated the Medicare antikickback statute and the Stark Law, thus causing claims for services submitted

[39] 989 F. Supp. 691 (W.D. Pa. 1997), *aff'd*, 1998-2 Trade Cas. ¶ 72,241 (1998).

[40] 243 F. Supp. 2d 843 (C.D. Ill. 2003).

[41] 31 U.S.C §§ 3729–3730 (1994).

by the hospital to Medicare and Medicaid for patients referred by those physicians to violate the False Claims Act. Among other things, the relator contended that the minimum volume requirement of 12 admissions a year for active medical staff appointees violated the antikickback statute. The court rejected that argument, stating that the active staff was merely a method of classifying medical staff appointees and not a referral requirement. According to the court, "The classification system is nothing more than a customary way of linking a physician's administrative and participatory responsibilities to his/her usage of the facility; physicians who routinely make greater use of the facility are expected to take on more responsibility and become more involved than a physician who seldom uses the facility."[42] The relator's complaint that he was denied "the benefit of having a voice in the hospital's administration and the opportunity to add patient clients by staffing the emergency room" because he was only on the courtesy staff was also rejected by the court, which said: "To accept Perales' argument would be tantamount to finding that hospitals cannot legally have a mechanism for classifying or regulating the privileges of physicians using its facilities. Such a holding would not only be unsupported by legal authority, but would also be contrary to public policy and violate common sense."[43]

In *Cobb County v. Prince*,[44] the Supreme Court of Georgia rejected a physician challenge to a hospital policy requiring that if a hospital patient required a treatment, procedure, diagnostic test, or other service, and the service in question was routinely offered by the hospital, then the patient would have to receive the test within the confines of the hospital. The physicians challenging the policy owned a free-standing CT scanning facility across the street from the hospital and wanted to refer patients there. In upholding the board's policy, the court said:

> The Hospital Authority's resolution requiring use of in-house facilities and services for hospitalized patients rather than permitting them to be taken

[42] *U.S. ex rel. Perales*, 989 F. Supp. 2d at 864.

[43] *Id.* at 865.

[44] 249 S.E.2d 581 (Ga. 1978).

from the hospital to utilize like facilities or services elsewhere is reasonable and reflects a well intentioned effort by the Authority to deal with the intricate and complex task of providing comprehensive medical services to the citizens of our state. The preeminent consideration in the adoption of such a resolution by the Authority was the health, welfare and safety of the patient. The Authority's resolution is a reasonable and rational administrative decision enacted in order for the Authority to carry out the legislative mandate that it provide adequate medical care in the public interest. The resolution does not invade the physician's province. Although he is required to use the facilities and equipment provided within the hospital complex for testing rather than similar facilities and equipment outside, he is nevertheless free to interpret the results of such tests and free to diagnose and prescribe treatment for all his patients.[45]

III. STATUTES ADDRESSING ECONOMIC CRITERIA FOR MEDICAL STAFF APPOINTMENT

A number of states have statutory provisions that specifically allow hospitals to base credentialing decisions on the utilization of their facilities by physicians seeking medical staff appointment or reappointment.[46] In such states, minimum volume requirements would be unquestionably valid. Other states have statutes that require hospitals to consider certain criteria such as the applicant's background, training, competence and experience when considering an application for medical staff appointment[47] or prohibit the consideration of criteria unrelated to standards of patient care, patient welfare, or the objectives of the institution.[48] Some have suggested that such statutes would prohibit a hospital from adopting policies that would render physicians with financial relationships with competitors ineligible for medical staff appointment. This argument has been rejected in the past.

---

[45] *Id.* at 587–88.

[46] *See* GA. CODE ANN. § 31-7-7 (2002); IND. CODE § 16-21-2-5(3)(C) (1998); MD. CODE ANN., HEALTH GEN. § 19-319 (2004); N.C. GEN. STAT. § 131E-85 (2005).

[47] *See* D.C. CODE § 32-1307 (2001); FLA. STAT. § 395.0191 (2006); IOWA CODE § 135B.7 (1997).

[48] *See* N.Y. PUB. HEALTH § 2801(2007); VA. CODE ANN. § 32.1-134.1 (2005).

In a September 22, 1998, letter to the President of the Pennsylvania Medical Society,[49] the Chief Counsel for the Pennsylvania Department of Health expressed an opinion that an "exclusivity" credentialing policy of a hospital did not violate a provision of the Hospital Licensing Regulations similar to the statutes described above, which prohibits hospitals from denying medical staff privileges on the basis of "any . . . criterion lacking professional or ethical justification."[50] The policy in question gave a "clear preference" to medical staff applicants who will perform 90% or more of their hospital clinical work at the hospital. The Department of Health found, among other things, that the hospital had a legitimate reason for adopting the policy, i.e., maintaining its viability in the face of a market that required the hospital to differentiate itself from its competitors. Therefore, the Department concluded that the criterion "was neither unprofessional nor unethical."

A few states prohibit hospitals from denying medical staff appointment in whole or in part because the physician is providing services at another facility.[51] However, such statutes would not preclude a hospital from conditioning eligibility for staff appointment on the lack of financial relationships with competitors, since, as stated above, such a policy would not preclude the physician from exercising privileges at other facilities. It would only limit the type of financial relationships that the physician could have with other facilities.

Only Illinois has addressed the issue of "economic credentialing" head on.[52] But even there, hospitals are still permitted to employ economic criteria in determining who can be on their medical staffs, as long as the physician is given notice of the reasons for the decision and the opportunity to be heard before the final decision is made.[53]

---

[49] Letter from James T. Steele, Esq. to Lee H. McCormick, M.D. (Sept. 22, 1998) (on file with author).

[50] 28 PA. CODE § 107.3(c) (2007).

[51] *See* R.I. GEN. LAWS § 23-17-52 (2006); TEX. HEALTH & SAFETY § 241.1015(b) (2003).

[52] 210 ILL. COMP. STAT. 85/2(b) (2007).

[53] 210 ILL. COMP. STAT. 85/10.4(b) (2007).

Hospitals in Illinois are also required to report adverse medical staff membership and clinical privilege decisions based substantially on economic factors to the Hospital Licensing Board before the decision takes effect, so that the Board can track these decisions for future reference.[54] Such reports would not have to be filed with the National Practitioner Data Bank pursuant to the federal Health Care Quality Improvement Act,[55] since a decision to deny medical staff appointment or clinical privileges solely on the basis that a physician has a financial relationship with the hospital's competitor would not constitute a reportable "professional review action" based on the clinical competence or professional conduct of the physician in question.[56]

IV. EXERCISE OF DISCRETION IN APPLYING POLICY

Since hospitals can deny eligibility for medical staff appointment, clinical privileges and other medical staff prerogatives based on the fact that a physician has a financial conflict of interest, hospitals also should have the discretion to apply those policies selectively in a manner determined by the governing body to be in the best interest of the community served by the hospital.

One example of where such discretion could be legitimately exercised is in the area of community need. A hospital in a rural area could be faced with competition from a physician-owned surgicenter and from an internal medicine practice that purchased equipment to perform nuclear cardiology studies on patients in its office rather than in the hospital. The hospital's governing body could determine, as part of its medical staff development planning process, that there are more than enough surgeons in the area to serve the needs of the community but a shortage of primary care physicians. Under these circumstances it would be legitimate for the hospital to enforce a policy denying medical staff appointment to the surgeons who have an ownership interest in the surgicenter, but not apply the policy

---

[54] 210 ILL. COMP. STAT. 85/10.4(c) (2007).

[55] 42 U.S.C. § 11101 (2007).

[56] 42 U.S.C. § 11151(9) (2007).

against the internists, since doing so could create serious access problems in the community.

Another basis on which the governing body could legitimately exercise discretion is the extent to which a particular competing facility or service could harm the hospital's ability to serve the community. For instance, a hospital could choose to exempt from the definition of competing financial relationships that would disqualify a physician from eligibility for medical staff appointment, ownership of basic office lab and x-ray services common in most medical practices, but apply the policy to physician offices that purchase sophisticated diagnostic equipment like nuclear cameras, MRIs or CT scanners.

This type of discretion could also involve the following scenario: plastic surgeons or ophthalmologists might own a surgicenter where they perform procedures for which they possess clinical privileges at the hospital but, in fact, would rarely if ever perform those procedures at the hospital due to scheduling problems or reimbursement issues. Their surgicenter would technically "compete" with the hospital because the procedures could be done at either place, but the hospital would experience little or no revenue loss as a result of this competition since the procedures would never have been done there in the first place. The hospital could determine that such "competition" would not trigger a determination of ineligibility for medical staff appointment. On the other hand, if a group of orthopedic surgeons or gastroenterologists announced that they had invested in a competing surgicenter and intended to move their work out of the hospital, the hospital would likely suffer a substantial loss of revenue. Under these circumstances, the hospital board should be able to determine that the physician owners would not be eligible for medical staff appointment since they would have a financial incentive to redirect patients/revenue away from the hospital to the facility that they own, which revenue diversion could jeopardize the hospital's continued ability to fund essential community services. Again, under such a policy, the hospital would not be requiring the physicians to refer any patients as a condition of maintaining their medical staff appointment. The physicians would simply be given a choice between their medical staff appointment

and a financial relationship that would induce them to refer elsewhere.

The hospital should also have discretion to determine whether a particular level of competition might affect its relationship with a physician while others may not. For example, it would be appropriate for a hospital to decide that ownership interest in a single-specialty acute care hospital that competes with it would render a physician ineligible for medical staff appointment, whereas ownership in an outpatient facility such as an ambulatory surgery center or independent diagnostic testing facility would not. The basis of such a decision would be that a facility that competes on both an inpatient and outpatient basis would pose an across-the-board threat to the hospital's mission and thus be a materially greater challenge than one that competed only in one line of outpatient business. Likewise, a hospital should be able to determine that employees of a competing hospital cannot have clinical privileges since they may compete not only with the hospital's own employed physicians, but also seek to gain access to patients through the hospital's ER call schedule and then divert them to their employer or a facility in which they have an ownership interest.

V. OTHER RESPONSES TO PHYSICIAN COMPETITION

Hospitals also have discretion to determine that certain types of financial relationships with competitors would affect a physician's relationship with the hospital in some ways but not in others. For instance, a hospital could legitimately determine that all competing financial relationships would disqualify a physician (or anyone else for that matter) from a seat on the hospital's board, since such relationships would be wholly inconsistent with a board member's fiduciary duty of loyalty to the hospital.

In the California case of *Desert Hospital v. Demiany*, two physicians who had served on the hospital's board had an ownership interest in a competing surgery center. They participated in all aspects of board discussions, including plans and discussions relating to the surgery center. Once the hospital took steps to move forward with these plans, the physicians and others filed suit to

stop the hospital. This was presumably to give them a chance to get their surgery center going before the hospital's. The hospital countered by suing the physicians for breach of their fiduciary duty. The litigation was contentious and protracted. It lasted four years and millions of dollars were spent in prosecuting and defending the actions. Ultimately, the hospital prevailed and the physicians were ordered to pay the hospital $13,452,000 in compensatory and punitive damages[57] for breach of fiduciary duty.

A hospital may also wish to adopt a policy that it will not enter into a financial relationship with anyone who has a financial relationship with the hospital's competitors. The kinds of financial relationships that can be denied to competitors of the hospital include employment, medical directorships, recruitment assistance agreements, and arrangements to assist with malpractice insurance premium increases or educational loan repayment.

Challenges by hospital competitors to the exercise of board discretion in crafting other types of responses to physician competition have failed in the past. In *Surgical Care Center of Hammond, L.C. v. Hospital Service District No. 1 of Tangipahoa Parish,*[58] a variety of hospital actions allegedly affecting a competing ambulatory surgery center were upheld in the face of an antitrust challenge. A federal court in New York dismissed a number of similar claims in the case of *Rome Ambulatory Surgery Center v. Rome Memorial Hospital,*[59] but declined to grant summary judgment to the hospital on the surgery center's claims that the hospital's exclusive contracts with two key insurance companies constituted attempted monopolization.

In *Woman's Clinic, Inc. v. St. John's Health System, Inc.,*[60] physicians who previously had been employed by an affiliate of the defendant

---

[57] Desert Hospital Corp. v. Smith, Case No. Indio 65391 (Cal. Super. Ct. Riverside County Dec. 4, 1995). This judgment was subsequently appealed, and on reconsideration after appeal and per agreement of the parties, in August 1998 damages were reduced to $1.00 per defendant.

[58] No. Civ.A. 97-1840 (W.D. La. 2000), *aff'd*, 309 F.3d 836 (5th Cir. 2002).

[59] 349 F. Supp. 2d 389 (N.D.N.Y. 2004).

[60] 252 F. Supp. 2d 857 (W.D. Mo. 2002).

health system challenged a "business covenant" that was part of their transition to private practice. The terms of the covenant provided that for a period of five years, plaintiff physicians could practice medicine in the area, but could not invest in or operate any ambulatory surgical center, birthing center, freestanding lab, or diagnostic service clinic, including mammography and ultrasound. The court rejected claims that this covenant violated federal or state antitrust laws, finding that it was a reasonable way for the health system to protect its interests.

In *Cogan v. Harford Memorial Hospital*,[61] a radiologist sued a hospital alleging violations of the Sherman Act, breach of contract, tortious interference with contractual relations, wrongful discharge, and violation of due process rights under § 1983 after the hospital terminated the radiologist's contract when he refused to agree to a new contract limiting his right to compete. The court rejected the radiologist's argument and granted the hospital's motion for summary judgment. Among other things, the court found that the hospital's refusal to allow the radiologist to refer patients to a competing clinic did not adversely impact competition.

In addition to determining that financial relationships with competitors would disqualify physicians from eligibility for medical staff appointment or clinical privileges or from the sorts of relationship described in the previous paragraph, hospitals should be able to deny competitors certain prerogatives if they are appointed to the medical staff. It would be legitimate for a hospital to adopt a policy denying physicians with competing financial relationships more favorable operating room time, participation on call rotations, the ability to vote at medical staff meetings, or medical staff leadership positions. Such policies would be rationally related to the fact that a physician with such a competing interest would not fully support the hospital and thus should not be able to take advantage of everything available to other physicians. For example, physicians with competing interests have been known to take advantage of emergency call to divert patients presenting to the hospital to their own facilities. This not only constitutes unfair competition, but could also jeopardize patient safety.

---

[61] 843 F. Supp. 1013 (D. Md. 1994).

VI. CONCLUSION

Based on the above, it is legitimate for hospitals to consider the effect of a physician's economic interests when considering requests for medical staff appointment, clinical privileges, or other prerogatives associated with the same.